DSS-106A
R. 3/90

Commonwealth of Kentucky
Cabinet for Families and Children
Department for Community Based Services

MEDICAL HISTORY

Child's Name_____ DOB:_____

INFORMATION PROVIDED BY : _____ Date:_____

Name and address of family doctor

_____

_____

Name of Health Carrier

_____

_____

MEDICAL ALERT THIS CHILD HAS A SERIOUS MEDICAL CONDITION

CONDITION

- ☐ Sickle Cell Disease
- ☐ Cardiac Problems
- ☐ Feeding/Eating Problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Medically Fragile
- ☐ Special Care/Requirement
- ☐ Respiratory Problems
- ☐ Other _____

_____

_____

ALLERGY

- ☐ Bee Stings
- ☐ Medication
- ☐ Food
- ☐ Poison Ivy
- ☐ Insect Stings
- ☐ Other_____

_____

_____

ADVERSE REACTIONS

- ☐ Rash
- ☐ Fever
- ☐ Swelling
- ☐ Respiratory Problems
- ☐ Other

_____

_____

_____

Recent Health Problems of child (describe illness, treatment, treatment provider.)

_____

_____

_____

_____

_____

_____

Current Medications? (Include cold /cough medicine, iron, vitamins, or any prescribed medication.)

_____

_____

_____

_____

_____

_____

Is child sexually active? _____
Any history of STD? _____
Date:_____
Treatment:_____

_____

_____

Does child use alcohol? _____
Tobacco? _____
Drugs? _____
Explain Frequency: _____

_____

_____

GIRLS ONLY: Age of menarche _____
Birth Control: Yes _____ **No** _____

Frequency _____
Method _____

Check if child has or has ever had the following illnesses (Record approximate date(s):

- ☐ Measles _____
- ☐ German Measles _____
- ☐ Jaundice _____
- ☐ Mumps _____
- ☐ Chickenpox _____
- ☐ Scarlet Fever _____
- ☐ Rheumatic Fever _____
- ☐ Heart Disease _____
- ☐ Heart Murmur _____
- ☐ Tuberculosis _____
- ☐ Allergies _____
- ☐ Intestinal Parasites _____
- ☐ Anemia _____
- ☐ Convulsions _____
- ☐ Seizures _____
- ☐ Joint Pain _____
- ☐ Muscle Pain _____
- ☐ GI Problems _____
- ☐ ENT Problems _____
- ☐ Urinary Problems _____
- ☐ Other Problem _____

_____

_____

Parent's Signature _____

Original, stays in Passport Folder
File: Copy Professional, Section III